

A CONSCIENCE-BASED HUMAN RIGHT TO BE 'DOCTOR DEATH'

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ABSTRACT

It is argued that a limited number of doctors may rely on article 9 ECHR to claim that they have a conscience-based right to assist the suicide of their legally competent adult patients who, for reasons of disability, are unable without assistance to put into action a voluntary, clear, settled and informed decision to kill themselves. In *Carter v Canada*, the Canadian Supreme Court rejected the proposition that an absolute ban on assisted dying was necessary to protect vulnerable individuals from the risks of requesting assisted dying for undue reasons. In *Nicklinson*, the UK Supreme Court did not substantively address that question and it is possible that it may soon have to address that question again. It is argued that in future litigation the UK Supreme Court should accept that an absolute ban disproportionately interferes with a doctor's conscience-based right to provide assistance in suicide. The argument relies on *Carter* and on the fact that a permissive legal regime is already in existence in the UK under administrative law principles.

1. INTRODUCTION

The supreme courts of the UK and Canada have recently expressed their opposing views on whether there is a human right to receive assistance in dying for someone who is incapable, due to disability, of taking his own life unaided. The appellant in *Nicklinson*¹ was a man completely paralysed, but for his head and eyes, who eventually starved himself to death. The majority of the UK Supreme Court refused

'(i) a declaration that it would be lawful for a doctor to kill him or to assist him in terminating his life, [and] (ii) a declaration that the current state of the law in that connection was incompatible with his rights under article 8 of the [European Convention on Human Rights ('ECHR')]'.²

The Canadian Supreme Court instead, in *Carter v Canada*, declared that

's. 241(b) and s. 14 of the Criminal Code are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition ... that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition.'²

The majority of the UK Supreme Court did not base its decision on its own conclusive view on the moral and legal debate on assisted dying. Instead, the majority held that the debate on assisted dying was best left, at least for the moment, to the democratically elected UK Parliament which was considering the Assisted Dying Bill at the time of the decision.³ The European Court of Human Rights ('ECtHR') has now approved of this decision to defer to Parliament when it rejected the admissibility

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¹ *R (Nicklinson) v Ministry of Justice* [2014] 3 WLR 200 at [5].

² 2015 SCC 5 at [127].

³ Lord Neuberger, Mance, Wilson, Reed and Clarke were of the view that Parliament ought to consider the question of the compatibility with human rights of the absolute ban of assisted dying before any judicial intervention. Lord Sumption and Hughes would leave this decision to Parliament entirely while accepting that courts generally have jurisdiction to assess the compatibility of statutes with human rights. Lady Hale and Lord Kerr, in the minority, would have granted the declaration sought by Mr Nicklinson.

of Mr Nicklinson's petition to the ECtHR following the Supreme Court's decision.⁴ The Canadian Supreme Court declined this approach of deferring to its own legislature. It upheld the decision of the trial judge Madam Justice Smith⁵ who had produced perhaps the most thorough and comprehensive judicial analysis of the moral and legal issues underlying assisted dying.

No doubt, should the issue of assisted dying reach the UK Supreme Court again, the possibility of which the Court has left open,⁶ the *Carter* decision will have a highly persuasive force. It is therefore appropriate and timely to speculate on how the UK Supreme Court might substantively deal in a future *Nicklinson* (n. 2) with the issues raised by assisted dying in light of *Carter*.

This paper argues that some doctors may be able to rely on recent ECtHR jurisprudence on article 9 ECHR (freedom of conscience and religion) to obtain a declaration from a UK court, under s. 4 of the Human Rights Act ('HRA'), of the incompatibility with the Convention of the absolute prohibition of assisted dying. Importantly, the legal effect of such declaration would not be the same as in Canada. Unlike the one granted under the Canadian Charter, a s. 4 declaration of incompatibility does not in fact affect neither the continuing operation or enforcement of the legislation declared incompatible. It merely requires Parliament to consider the incompatible legislation and, if it so deems, to remedy the incompatibility.⁷ There is however some evidence to suggest that such declaration would create a serious political pressure on the UK Parliament and it would take weighty counter-veiling considerations for the UK Parliament not to enact law to remedy the incompatibility.⁸

The choice of this doctor-focused perspective may be justified by the fact that the liability imposed by the criminal prohibition of assisted dying is not on the person seeking assistance but instead on the person providing it, as it is legal in the UK for a person to commit or attempt suicide.⁹

Secondly, a doctor is not only potentially criminally liable for assisting a patient's dying. He is also likely to be sanctioned by his professional regulator, the General Medical Council ('GMC'). Guidance by the GMC provides that as a result of assisting a patient's death a doctor's licence to practise medicine may be revoked.¹⁰ Being a public body, the GMC is obliged under s. 6 HRA to act in a manner compatible with the ECHR. A declaration that a doctor has a Convention right to provide assistance in dying may therefore invalidate the GMC's guidance and may consequently prove necessary for the doctor to maintain the source of his livelihood. This argument appears even more urgent now that the Divisional Court has rejected, relying on *Nicklinson* but not mentioning *Carter*, the incompatibility of the GMC's guidance with article 8 ECHR (right to private and family life).¹¹

Finally, a perspective focused on a doctor's conscience may provide a fresh and legally untested approach which may open up new avenues for advocates of the relaxation of the law on assisted dying.

⁴ *Nicklinson and Lamb v UK* (application nos. 2478/15 and 1787/15), unreported (16 July 2015), paragraph [84].

⁵ *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (CanLII).

⁶ See n 1 above in the opinions of Lord Neuberger, Wilson, Mance and Clarke.

⁷ The procedure is set out in s. 10 and Schedule 2 of the HRA.

⁸ See C. Chandrachud, 'Reconfiguring the discourse on political responses to declarations of incompatibility' [2014] Public Law 624.

⁹ Section 1 of the Suicide Act 1961 decriminalises suicide. Section 2 of the same act criminalises a person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide. The prohibition of euthanasia falls under the general common law prohibition of murder.

¹⁰ General Medical Council, 'Guidance for the Investigation Committee and case examiners when considering allegations about a doctor's involvement in encouraging or assisting suicide' (March 2013). Available at http://www.gmc-uk.org/DC4317_Guidance_for_FTP_decision_makers_on_assisting_suicide_51026940.pdf.

¹¹ *R. (on the application of AM) v GMC* [2015] EWHC 2096 (Admin).

The paper first rejects the preliminary objection that it would be constitutionally inappropriate for the UK Supreme Court to declare the blanket prohibition of assisted dying incompatible with human rights. The paper then explains under what conditions a doctor may claim a conscience-based right to assist dying. It then goes on to identify as a legitimate aim for interfering with this right the preoccupation that the right may expose vulnerable members of society to unwarranted risks. This justification for interfering with the right will be partially rejected relying on the reasoning in *Carter*. However, it will also be argued that such interference cannot be justified in the UK because a permissive legal regime already exists in the UK under administrative law principles. This argument relies on the Parliament-endorsed policy of the Director of Public Prosecutions (DPP) on assisted suicide and on the way it has been applied by the DPP.

2. THE CONSTITUTIONAL OBJECTION

The argument to be made in parts 3-4 that the UK Supreme Court should issue a s. 4 declaration cannot get off the ground if the following objection, call it the constitutional objection, cannot be met. The objection says that it would be constitutionally inappropriate for the UK Supreme Court to declare the absolute prohibition of assisted dying, in particular of assisted suicide, incompatible with the ECHR when the UK Parliament has determined multiple times to keep that prohibition absolute. The UK Parliament enacted the prohibition of assisted suicide in 1961 and re-enacted the prohibition in substantially similar form in 2009 in the Coroners and Justice Act 2009. Furthermore, following *Nicklinson*, in September 2015 the House of Commons debated the Assisted Dying (No. 2) Bill which would have relaxed the prohibition and voted by a very large majority to reject the Bill.¹² It would be inappropriate, goes the objection, for the courts to question the committed verdict of the UK's democratically-elected legislature on a matter of profound moral contention. In *Nicklinson* the constitutional objection had its strongest proponents in Lord Sumption, joined by Lord Hughes.¹³ The objection also informed, although did not determine, the view of the majority not to issue a s. 4 declaration in view of the (at the time) pending decision of Parliament on the Assisted Dying Bill.¹⁴ The objection therefore needs to be addressed as it is possible it may be perceived as a barrier to issuing a s. 4 declaration in a possible *Nicklinson* (n. 2).

Lord Sumption's adherence to the constitutional objection was animated by the conviction that, first, the highly contentious issue of assisted dying requires resolution by a democratic institution; second, that the UK Parliament had decided the issue multiple times and had decided to keep the absolute ban; and finally, the legislature was best placed to decide the issue because it had access to a fuller range of expert judgment and experience than courts.¹⁵ In order to address the constitutional objection two arguments will be presented. The first argument takes the sting out of Lord Sumption's first and third points (i.e. legislative democratic legitimacy and legislative expertise). The second argument undermines Lord Sumption's second point (i.e. legislative unswerving verdict on the issue).

The first argument against the constitutional objection says that issuing a s. 4 declaration does not in fact require the judiciary to undertake a legislative role which, as Lord Sumption argues, would require the democratic legitimisation or legislative expertise which the UK Parliament has. In particular, as stated in the introduction, a s. 4 declaration would not affect the legal validity of the absolute prohibition of assisted dying. The judiciary would therefore not be effecting any change in

¹² Hansard, HC Vol. 599, cols 656 – 725 (September 11, 2015).

¹³ *Nicklinson* (n 1), paragraphs [267],

¹⁴ *Nicklinson* (n 1), paragraphs [77] – [118].

¹⁵ *Nicklinson* (n 1), paragraphs [230] – [232].

the law by making such a declaration and, consequently, need not have any democratic mandate or legislative expertise to issue it.¹⁶

Different considerations would apply altogether if the Supreme Court was asked to use the interpretative power afforded to it under s. 3 HRA so as to create an exception from the absolute prohibition for individuals in Mr Nicklinson's situation. The interpretative power, if used, would require the judiciary to, in effect, devise a legislative scheme which would relax the absolute prohibition. That judicial legislative scheme, the objection goes, would require democratic legitimisation and legislative expertise. But no party in *Nicklinson* advanced the submission that the judiciary could or should use the interpretative power under s. 3 in this instance. It is not the purpose of this paper to argue that the judiciary should use the s. 3 power. The purpose of the paper is to set a novel legal ground for issuing a s. 4 declaration. Contrary to Lord Sumption's view, in as much as the remedy sought in a future *Nicklinson (n. 2)* is a s. 4 declaration, the judiciary would not be usurping Parliament's role in issuing the declaration. On the contrary, one should conclude that by issuing a declaration, the judiciary would instead be summoning Parliament, with its legitimacy and expertise, to draw its mind to the effects that the absolute prohibition has on individuals in Mr Nicklinson's position (i.e. disabled individuals who wish to be helped to commit suicide).

The first argument may be granted. However, Lord Sumption's second point would still remain unaddressed. This says that Parliament has considered the issue of assisted dying multiple times and has always reached the same conclusion. Why then should a declaration of incompatibility be issued thereby requiring Parliament to repeat once again what it has said multiple times with the consequent loss of precious parliamentary resources? This objection, grounded on the practical consideration of safeguarding precious parliamentary resources, would bite if Parliament had directly confronted the issue raised by *Nicklinson*. It is doubtful that it did. There was very little mention, 7 times only,¹⁷ and virtually no discussion in the extensive House of Commons debate on the Assisted Dying (No. 2) Bill of the effect the absolute prohibition is having on individuals in Mr Nicklinson's position. The parliamentary debate was instead focused on the possibility of permitting assisted suicide for individuals, not necessarily disabled, that had been diagnosed with a terminal illness and had an estimated prognosis of 6 months left to live, as that was the focus of the Bill. A s. 4 declaration would require Parliament to address the pressing issues that the UK and Canadian courts had to deal with and which the House of Commons did not directly debate.

What is argued here is that, rather than a tool mandating a waste of Parliamentary resources in this instance, a s. 4 declaration should instead be viewed as a precious Parliamentary resource in the debate on assisted dying. It can be reasonably assumed that a s. 4 declaration will always be accompanied by a detailed judicial analysis of the legal reasons why it has been made. That explanation can then be used as a resource by Parliament to reach a definite answer on the same issue highlighted by the declaration. It is not argued here that any possible relaxation of the absolute prohibition by Parliament should only be motivated by legalistic human rights considerations. Surely, Parliament should also consider the wider political, social and moral issues which the absolute prohibition involves. Nevertheless, it does not seem particularly controversial to argue that Parliament can benefit from the judiciary's legal insights on the issue. This is so especially when those insights reveal unexpected interferences with Convention rights such as the one argued for in this paper (i.e. a doctor's conscience-based right to assist suicide). If the Supreme Court issued a declaration on this basis, it would constitute a valuable insight, at least because it is novel, which Parliament would benefit from discussing.

¹⁶ See E. Wicks, 'The Supreme Court Judgment in *Nicklinson*: One Step Forward on Assisted Dying; Two Steps Back on Human Rights' 23 (1) Medical Law Review 144, 153-155.

R. Nobles and D. Schiff, 'Disobedience to Law – Debbie Purdy's Case' 73 Modern Law Review 295

¹⁷ Hansard, HC Vol. 599, cols 656, 673, 675, 690, 692, 698, 722.

To sum up, the constitutional objection should be rejected. A s. 4 declaration would call on Parliament, not the judiciary, to exercise its legislative judgment on an issue which it has not squarely confronted, at least in the latest debate. Also, a s. 4 declaration would enhance the quality of Parliamentary debate on the issue because it would provide the occasion for the Supreme Court to provide Parliament with valuable legal insights of the consequences should Parliament decide to maintain the absolute prohibition.

3. CONSCIENCE IN ASSISTING DYING

The previous section discussed why it would not be constitutionally inappropriate for the UK Supreme Court to make a s. 4 declaration. This section and the next argue that the declaration can be made on the basis of article 9.

In *Pretty v UK*, the ECtHR quickly dismissed the submission that the applicant, a disabled individual seeking assistance in suicide, had an article 9 right to receive assistance from her husband because 'she believed in and supported the notion of assisted suicide for herself'.¹⁸ While accepting the firmness of her views, the Court held that not all opinions or convictions constitute beliefs in the sense protected by article 9.¹⁹ Importantly, the Court held that putting into practice her conviction on the moral rightness of assisted suicide is not protected by article 9. The Court found instead that the applicant's article 8 right to private and family life was engaged but that, bearing in mind the wide margin of appreciation afforded to the UK, the criminal prohibition of assisted dying was justified.²⁰

The finding in *Pretty* that article 9 was not engaged at all appears to create a serious challenge to the proposition that a doctor may have a conscience-based right to assist a patient in dying. After all, if the direct beneficiary of the assistance cannot claim a conscience-based right, why should the provider of the assistance be able to? Various ways to meet this challenge are explored below.

Autonomy v Conscience

The first way to overcome the *Pretty* challenge is to note that the court's finding that article 9 was not engaged was influenced by the self-beneficial nature of the applicant's conviction. The judgment reports that the applicant 'believed in and supported the notion of assisted suicide *for herself*'.²¹ Given that her view was self-beneficial it is less straightforward to say that her view on assisted suicide relies on the value of conscience rather than on the related, but distinct, value of autonomy (i.e. on the control she ought to have on how to live and end her life). It is no surprise then that the Court found that 'to the extent that the applicant's views reflect her commitment to the principle of personal autonomy, her claim [under Article 9] is a restatement of the complaint raised under Article 8'.²²

In the context of a doctor wishing to provide assistance in dying to another, it is less likely that issues of autonomy and self-benefit may arise to block a finding that a doctor is acting out of conscientious conviction. In fact, it is entirely plausible that a doctor may provide assistance in dying to a non-related person, not for personal gain, and out of a conscientious conviction that assisted dying is not only morally permissible but, in some tragic cases and when explicitly requested, morally required.

¹⁸ (2002) 35 EHRR 1 at [80].

¹⁹ Ibid at [82] – [83].

²⁰ Ibid [61] – [78].

²¹ Ibid at [80] (emphasis added).

²² Ibid at [82].

There is a public account of such an episode in the DPP's published decision not to prosecute Dr Michael Irwin, one of the assistants of the suicide of Raymond Cutkelvin.²³

Mr Cutkelvin suffered from inoperable pancreatic cancer and wished to use the services of *Dignitas*, a Swiss clinic which provides assistance in dying. *Dignitas* asked one of its members, Dr Irwin, to contact Mr Cutkelvin and to explain the associated procedure. Dr Irwin, who had no previous relationship with Mr Cutkelvin, met with him and also made a substantial financial contribution (£1,500) out of his own pocket towards Mr Cutkelvin's travel costs to *Dignitas*. At the clinic, Mr Cutkelvin committed suicide.

The DPP decided not to prosecute Dr Irwin based on his finding that the doctor acted out of sympathy towards Mr Cutkelvin and because he was 'motivated by a strong belief that the law on assisted suicide is wrong and it is legitimate to assist those who wish to travel to *Dignitas* to commit suicide.'²⁴ This finding is consistent with an earlier public statement by Dr Irwin that:

'I believe passionately that in this apparently enlightened 21st century, terminally ill patients should have the right to obtain medical assistance to die [...] I strongly believe that the existing law on assisted suicide is unjust [...]'²⁵

In light of Dr Irwin's case, it is plausible to think that he or another doctor holding similar beliefs could reasonably invoke article 9 and not be found, as in *Pretty*, to be actually making an autonomy-related claim under article 8. Dr Irwin (or a doctor with similar convictions) could meet the *Pretty* challenge, as he was not assisting a relative, was found by the DPP not to be acting for personal gain (and actually lost out monetarily) and was found to be acting out of his deeply held belief that the law on assisted dying is morally wrong.

The Bayatyan test

There is a doctrinal basis to think that some doctors wishing to assist their patients' dying may successfully rely on article 9 to meet the *Pretty* challenge. The jurisprudence on article 9 has recently received a more generous interpretation than it has ever had in the past. Particular reference has to be made to the jurisprudence of the ECtHR on conscientious objection and, in particular, to the case of *Bayatyan v Armenia*.²⁶

In brief, the *Bayatyan* concerns the unprecedented recognition under article 9 of the right to exemption from military conscription for conscientious objectors. The relevant part of the judgment is the following test set by the ECtHR of when article 9 can be held to be engaged:

'[The Court] considers that opposition to military service, where it is motivated by a serious and insurmountable conflict between the obligation to serve in the army and a person's conscience or his deep and genuinely held religious or other beliefs, constitutes a conviction or belief of sufficient cogency, seriousness, cohesion and importance to attract the guarantees of Article 9'.²⁷

There is obviously much that is very specific to the circumstances of the case in the above test set in *Bayatyan* which is not of direct relevance here. However, one can still extrapolate the crucial test

²³ DPP/CPS, 'No charges following death of Raymond Cutkelvin' (25 June 2010) available on the CPS's website at http://www.cps.gov.uk/news/articles/the_suicide_of_mr_raymond_cutkelvin_decision_on_prosecution/. Unless otherwise stated, all URLs were last accessed on 18 August 2015.

²⁴ Ibid at [41].

²⁵ Clare Dyer, 'Euthanasia law must change, says struck-off doctor' *The Guardian*, 28 September 2005 available at <http://www.theguardian.com/society/2005/sep/28/health.medicineandhealth>.

²⁶ (2012) 54 EHRR 15.

²⁷ Ibid at [110]. This has been followed more recently in *Buldu and Others v. Turkey* ECtHR 3 June 2014. It has also received approval in the landmark case of *Eweida and others v UK* (2013) 57 E.H.R.R. 8, at [81].

for when a moral conviction can be protected under article 9. Three distinct limbs are suggested here.

1. There must be a 'serious and insurmountable conflict' between a legal prohibition and a person's conscience or deeply and genuinely held religious or non-religious beliefs;
2. The person's conviction or belief must be of sufficient cogency, seriousness, cohesion and importance to attract the guarantees of article 9; and
3. It is more likely that article 9 is engaged when the person seeking to escape a legal prohibition is not doing so 'for reasons of personal benefit or convenience but on the ground of his genuinely held religious [or non-religious] convictions'.²⁸

The first two limbs of the test have been taken from the quotation in *Bayatyan* above whereas the third follows from the discussion in the previous section on self-beneficial convictions (better protected under article 8) and from a later passage in *Bayatyan*.

It is possible to mount an argument that a doctor in similar circumstances to Dr Irwin may be able to satisfy the *Bayatyan* test. The first limb of the test may be held to be satisfied in his case as his conscience, as testified by the DPP, dictates that he must provide assistance in dying to certain patients despite the criminal prohibition. The conflict is insurmountable without sacrificing his beliefs – the doctor either abandons his conscience or follows the law. The conflict is also serious – unless he yields to the obligation he may be criminally sanctioned.

The third limb of the test, on not making a self-beneficial claim, may also be held to be satisfied. The DPP has testified that Dr Irwin 'was not motivated by the prospect that he stood to gain in some way from Mr Cutkelvin's death'. Instead the DPP concluded that 'Dr Irwin had mixed motives (i.e. a strong belief that the law is wrong and that his actions were legitimate mixed with personal sympathy for [Mr Cutkelvin's] situation'.²⁹

It is in relation to the second limb of the test that many doctors wishing to rely on this right may encounter an unsurmountable evidential problem. A proper analysis of the test reveals that it requires that the doctor's convictions be cogent, serious, coherent and important. The burden is to show that one actually cogently and seriously holds that conviction (and is not merely asserting it as a matter of convenience to escape the criminal penalty) and that the conviction stands up to close scrutiny (i.e. is it a coherent conviction and important for the person).

Arguably Dr Irwin, unlike many doctors prepared to assist their patients' to die, would be able to provide sufficient evidence to meet the second limb of the test. This is because his commitment to assisted dying has been highly publicised over the years and is an indistinguishable part of his public profile. He was chair of Dignity in Dying, the main UK charity committed to the relaxation of the prohibition of assisted dying, and he established the Society for Old Age Rational Suicide.³⁰ As shown above, the DPP has accepted that Dr Irwin is deeply committed to the change in the law of assisted dying. However, it is unlikely that many doctors that support assisted dying would have built the same profile as Dr Irwin. It might therefore be more difficult for them to adduce evidence to convince a court that their conviction on the morality of providing assisted dying is cogent, serious, coherent and important enough to warrant the protection of article 9.

Conscience in actively assisting dying

²⁸ Above n 26 at [124].

²⁹ Above n 23 at [41].

³⁰ A brief biography of Dr Irwin can be seen on the British Humanist Association website at <https://humanism.org.uk/about/our-people/patrons/Dr-Michael-Irwin/>.

Even if Dr Irwin, or another doctor similarly placed, may be held to satisfy the *Bayatyan* test there are still various doubts which may block the conclusion that a doctor has a conscience-based right to provide assistance in dying.

The first doubt is that conscience-based rights are often claimed as rights to be exempt from performing a given act. In the UK, for example, a person with a conscientious objection may claim to be exempt from performing acts authorised or required by the Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990. The doubt then is whether freedom of conscience as protected under article 9 can allow a person to perform the positive act of providing assistance in dying to another.

The way around this first doubt is to show that it is overly simplistic. Conscience-based rights should not be conceptualised as only covering refusals to perform certain acts. In fact the text of article 9 clearly indicates that the Convention right to freedom of conscience and religion covers positive acts and, in particular, guarantees to the person invoking it the right 'to manifest his religion or belief, in worship, teaching, practice and observance'. Furthermore conscience-based rights, and in particular article 9, are capable of justifying simultaneously both the performance of certain positive acts and claims for exemptions from performing other acts. This can be seen clearly in the landmark case of *Eweida and others v UK*.³¹

Ms Chaplin, the second applicant in that case, was a practising Christian and a nurse at an NHS Trust. She wished to visibly wear a cross on a chain around her neck to express her faith. Her employer lawfully ordered her to remove the chain or conceal it on the ground that it could be a safety hazard by, for example, coming into contact with open wounds. Ms Chaplin argued that article 9 provided her with a right to visibly wear the cross on a chain. In making that argument, Ms Chaplin was effectively stating that she had an article 9 right to perform both a positive act, i.e. visibly wear the cross, and a negative one, i.e. being exempt from complying with a lawful order of her employer which she would, but for the conscience-based claim, be legally obliged to comply with.³² The ECtHR sided with her in this respect. It agreed that article 9 provided protection to her claim and that her employer had interfered with her article 9 right. However, in deference to the domestic authorities' assessment of the dangers to patients if allowed to wear the cross on the necklace, the ECtHR concluded that the interference was justified.

The case of Ms Chaplin offers relief from the first doubt while imposing another more serious one. The first doubt is relieved as the case provides authority for the proposition that article 9 may be properly relied on by a doctor who wishes to perform both a positive act (e.g. provide assistance in dying to another) and a negative one (e.g. claiming exemption from complying with the criminal prohibition of assisted dying). The second and more serious doubt created by the case is the fact that an interference with article 9 is likely to be found justified if the exercise of the right is likely to put at risk the safety of others. A doctor wishing to provide assistance in dying to another clearly undermines the safety of the person requesting assistance as the expected result of such assistance is the death of the requestor. Does this not mean then that the criminal prohibition of assisted dying is very likely to be considered a justified interference with the doctor's conscience-based right as long as the prohibition is animated by the aim to protect the safety of the person requesting assistance?

We can overcome the second doubt by showing that the protection of the safety of a person seeking assistance to die who is 'a mentally competent adult who knows her own mind, who is free from

³¹ Above n 27.

³² An employee has a duty at common law to obey the lawful and reasonable orders of the employer. See *Gregory v Ford* [1951] 1 All ER 121 and *Morrish v Henlys (Folkestone) Ltd* [1973] ICR 482.

pressure and who has made a fully informed and voluntary decision³³ is not a legitimate aim which may be pursued by the UK through the criminal prohibition of assisted dying. The ECtHR said as much in *Pretty*. The Court stated that the applicant, described as a mentally competent adult, had an autonomy-based article 8 right to decide how to end her life and had a right to seek assistance to undermine her own personal safety. The UK could not interfere with that right for paternalistic reasons. In the Court's words:

'The Court would observe that the ability to conduct one's life in a manner of one's own choosing may also include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned. [...] [E]ven where the conduct poses a danger to health, or arguably, where it is of a life-threatening nature, the case-law of the Convention institutions has regarded the State's imposition of compulsory or criminal measures as impinging on the private life of the applicant within the scope of Article 8(1) and requiring justification in terms of the second paragraph.'³⁴

The statement of the Court is on point to clear the second doubt. A competent adult person who has made a fully informed and voluntary decision to receive assistance in dying exercises his Convention right, under article 8, to choose how to die and a doctor providing such assistance promotes, not contravenes, the Convention right of the requestor. This situation is far removed from the case, as in *Chaplin*, where the exercise of an article 9 right may undermine the safety of a person that has not consented to the infliction of bodily harm.

It should be emphasised that the clearing of this second doubt does not prejudice the fact that there might be another aim which may ultimately justify interference with a doctor's conscience-based right to provide assistance in dying to a patient. This may be 'protecting the weak and vulnerable and especially those who are not in a condition to take informed decisions against acts intended to end life or to assist in ending life'.³⁵ This forms the subject of the next part of the paper. It is argued that this aim cannot ultimately justify the interference with the conscience-based right created by the absolute prohibition.

4. THE NECESSITY AND PROPORTIONALITY OF INTERFERENCE WITH A CONSCIENCE-BASED RIGHT FOR 'DOCTOR DEATH'

It has been argued that, if certain conditions are met, article 9 may be engaged and the absolute prohibition on a doctor of assisting a patient's dying may constitute an interference with a conscience-based right. However, as is well known, article 9 is not an absolute right and showing that it is being interfered with is only the first step of a successful challenge to the absolute prohibition of assisted dying. The prohibition may be held proportionate and hence justified if it is (in the words of Lady Hale)

'(i) for a legitimate aim which is important enough to justify interfering with a fundamental right, (ii) rationally connected to achieving that aim, (iii) no more than reasonably necessary to achieve it, and (iv) in the light of this, striking a fair balance between the rights of the individual and the interests of the community'.³⁶

In both *Carter* and *Nicklinson*, Canada and the UK advanced the proposition that the criminal prohibition of assisted dying proportionately pursues the legitimate aim of 'the protection of vulnerable people, those who feel that their lives are worthless or that they are a burden to others

³³ Above n 27, at [72].

³⁴ Above n 27, at [62].

³⁵ Above n 27, at [74].

³⁶ Above n 1 at [310].

and therefore that they ought to end their own lives even though they do not really want to'.³⁷ It is highly likely the same assertion would be repeated in a possible *Nicklinson* (n. 2) by the UK.

It will be argued that the UK has forfeited its ability to argue that an absolute prohibition proportionately pursues the legitimate aim of the protection of vulnerable people. *Carter* provides a good starting point for the argument that an absolute prohibition is not necessary. Ultimately, however, it is the fact that there is already in the UK a permissive legal regime under administrative law which provides the most compelling reason against the proportionality of the absolute prohibition.

The Necessity of the absolute prohibition in Carter v Canada

There are various reasons to think that *Carter* will have a limited role in a possible *Nicklinson* (n. 2). Firstly, it is a judgment of a foreign court and therefore carries only persuasive and not precedential weight. Secondly, and importantly, *Carter* was decided on the basis of the Charter's section 7 right to life, liberty and security of the person. The comparable ECHR article 2 right to life was explicitly held both in UK courts and in the ECtHR not to be even engaged. Instead, in *Pretty v UK* and in *Nicklinson* the courts recognised that article 8 was engaged.³⁸

While *Carter* should therefore be used with caution, it nevertheless provides invaluable guidance on the core issue of whether an absolute ban on assisted dying is a necessary interference with a fundamental right, independently of whether it is the right to life, private and family life or the right to manifest conscience. In particular, in relation to the third limb of the proportionality test, the Canadian court has held that an absolute ban is not necessary to ensure the protection of vulnerable individuals who may ask for assistance in dying for inappropriate reasons. The Canadian Supreme Court undertook a close assessment of the conclusions of the trial judge who had undertaken a herculean review of oral and written evidence provided by several experts. Four points succeeded in convincing the Supreme Court that an absolute prohibition was not necessary to protect vulnerable individuals.

First, the Court rejected Canada's assertion that an absolute ban was necessary to protect decisionally vulnerable patients who did not have a rational and considered desire for death. The Court held that the trial judge had not erred when she found that Canadian doctors can appropriately detect and reject requestors who suffer from depression or other mental illnesses, or who are under coercion, undue influence or manipulation. Furthermore, the Supreme Court affirmed the trial court's finding that doctors may appropriately use in their assessment the same procedures they use when investigating informed consent and decisional capacity in other end-of-life medical contexts.³⁹

Second, the Court was persuaded by the trial judge's finding that the risks associated with a permissive regime can be limited 'through a carefully designed and monitored system of safeguards'.⁴⁰ The Court did not clearly state which safeguards could be implemented. However, it is instructive to note in this regard that the trial judge's review of permissive regimes abroad focused on Oregon, Netherlands and Belgium where doctors are the final arbiters of who is decisionally competent to request assistance in dying.⁴¹ This contrasts with the proposal put forward by some of the Justices of the UK Supreme Court in *Nicklinson* that a judge, not a doctor, could be the final

³⁷ Ibid at [311] (Lady Hale).

³⁸ Above n 1. Above n 18 at [50].

³⁹ Above n 2 at [114] - [116].

⁴⁰ Ibid at [117].

⁴¹ Above n 5 in part VIII of the judgment.

arbiter after having heard evidence from doctors, family members and the person requesting assistance to die.⁴²

Third, the Canadian Supreme Court was not persuaded by Canada's assertion that any proposed safeguards would be insufficient unless it could be demonstrated that the safeguards eliminated all potential risks. The Supreme Court's response was stark: 'A theoretical or speculative fear cannot justify an absolute prohibition [...] [The proportionality assessment] is a process of demonstration, not intuition or automatic deference to the government's assertion of risk'.⁴³

Finally, the Supreme Court rejected the often made 'practical slippery slope argument'⁴⁴ which says that 'without an absolute prohibition on assisted dying, Canada will descend the slippery slope into euthanasia and condoned murder'.⁴⁵ Reference by the Court to 'a slippery slope into euthanasia and condoned murder' should be read to refer to practices of involuntary or non-voluntary euthanasia, i.e. where the person has not given or cannot give valid consent (e.g. because lacking in mental capacity or being a minor). The Court stated that 'We should not lightly assume that the regulatory regime [...] will function defectively, nor should we assume that other criminal sanctions against the taking of lives will prove impotent against abuse'.⁴⁶

While the conclusion of the Canadian Court that appropriate safeguards can be put in place in a permissive regime is likely to be taken seriously by the UK Supreme Court in a possible *Nicklinson* (n. 2), it is unlikely to win the day for the reasons already explained. Hence, it is necessary to point to a supplemental and UK-specific argument to convince a UK court that an absolute prohibition disproportionately interferes with a doctor's conscience-based right to provide assistance in dying. This is the aim of the next section

The existing UK permissive legal regime for assisting suicide

It is here argued that as a matter of UK administrative law an absolute ban on assisted dying has been accepted in the UK as not necessary. It is argued that the way the 2010 DPP's policy on the prosecutions of assisted suicide has been applied indicates that doctors and family members assisting dying have a legal right in administrative law, under certain circumstances, to be immune from legal prosecution from the offence of assisted suicide. If this is true, then it is not possible for the UK to argue that an interference with a doctor's conscience-based right to provide assistance in dying through an absolute ban is necessary in order to protect the vulnerable. This is because there already exists in the UK, with Parliamentary approval, a permissive regime under administrative law. Importantly, the argument does not assert that there is in the UK a legal right to immunity for doctors or family members to perform euthanasia as the policy only applies to assisted suicides.

Only the DPP can authorise a prosecution for the offence of assisted suicide⁴⁷ and he was required by the House of Lords in *Purdy v DPP*⁴⁸ to issue statutory guidance⁴⁹ on how he would exercise his discretion to authorise a prosecution. The DPP published the final version of his policy after a wide public consultation in 2010.⁵⁰ On 27 March 2012, the House of Commons, after a long debate,

⁴² Above n 1: Lady Hale at [314] – [315]; Lord Neuberger at [124] – [125]; and Lord Kerr at [355].

⁴³ Above n 2 at [119].

⁴⁴ See for example chapter seven of Keown, *Euthanasia, Ethics, and Public Policy* (Cambridge: Cambridge University Press, 2002).

⁴⁵ Above n 2 at [120].

⁴⁶ Ibid.

⁴⁷ Under section 2(4) of the Suicide Act 1961.

⁴⁸ *R. (on the application of Purdy) v DPP* [2010] 1 AC 345.

⁴⁹ Under section 10 of the Prosecution of Offences Act 1985.

⁵⁰ DPP, 'Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide' (February 2010, updated October 2014) available at http://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html.

passed a motion resolving that 'this House welcomes the Director of Public Prosecution's Policy to Prosecutors in Respect of Cases of Encouraging or Assisting Suicide, published in February 2010 [...]'.⁵¹

Under the DPP's policy on assisted suicide (PAS) a prosecution for assisting someone's suicide will be authorised only if there is sufficient evidence to bring a successful prosecution and only if the prosecution is required in the public interest. In relation to the public interest stage, the PAS sets out 16 factors to be taken into account in favour of prosecution and 6 factors against prosecution.⁵²

Some have argued that it is entirely possible to imagine a scenario where the factors against prosecution will all be triggered and a person who has provided assistance may be fairly confident that no prosecution will take place.⁵³ In fact, there is some weighty evidence to go further than this and to sustain the proposition that it is not necessary for all these factors to be triggered and that no prosecution is likely to take place as long as the following three 'Determining Factors' are present:

1. the assisted was a legally competent adult who had reached a voluntary, clear, settled and informed decision to commit suicide;
2. the assisted suffered from a medical condition, not necessarily terminal, causing him severe physical or mental distress; and
3. the provider of the assistance did not have improper motives for his actions and did not exert undue influence on the assisted.

The evidence in favour of this view can be extracted by reviewing the publicly available decisions of the DPP on prosecutions for assisted suicide. There are currently six decisions available where the DPP has decided not to prosecute despite having sufficient evidence for a successful prosecution and a series of factors in favour of prosecutions.⁵⁴ A review⁵⁵ of these decisions reveals that in all these

⁵¹ HC Deb vol 542 column 1440 27 Mar 2012.

⁵² At [44] of the PAS, the six factors against prosecution are:

1. The victim had reached a voluntary, clear, settled and informed decision to commit suicide;
2. the suspect was wholly motivated by compassion;
3. the actions of the suspect, although sufficient to come within the definition of the offence, were of only minor encouragement or assistance;
4. the suspect had sought to dissuade the victim from taking the course of action which resulted in his or her suicide;
5. the actions of the suspect may be characterised as reluctant encouragement or assistance in the face of a determined wish on the part of the victim to commit suicide;
6. the suspect reported the victim's suicide to the police and fully assisted them in their enquiries into the circumstances of the suicide or the attempt and his or her part in providing encouragement or assistance.

⁵³ See for example R. Nobles and D. Schiff, 'Disobedience to Law – Debbie Purdy's Case' 73 Modern Law Review 295, in particular footnote 19. The DPP himself has admitted in the decision not to prosecute Michael Bateman for the assistance of his wife's suicide that there were no PAS factors in favour of prosecutions. See DPP/CPS, 'Assisted suicide charge not in the public interest' (24 May 2010) available at http://www.cps.gov.uk/news/latest_news/120_10/.

⁵⁴ The decision not to prosecute anyone for the suicide of Jane Hodge is not included in this number. The DPP did not prosecute anyone because of lack of sufficient evidence that she was assisted in her suicide. Jane had no reported medical conditions. She was 91 years of age when she committed suicide. See DPP/CPS, 'CPS decides no charges following the death of Jane Hodge' (02 February 2010) available at http://www.cps.gov.uk/news/latest_news/106_10/.

⁵⁵ Daniel James was diagnosed as tetraplegic, paralysed from the chest down and with no independent hand or finger movement.

Sir Edward and Lady Downes committed suicide in Switzerland. She had terminal cancer while he had various health problems (including much reduced eyesight).

Margaret Bateman had been suffering from chronic pain for years.

cases the person assisted, either suffering from severe disability or from a terminal illness but an adult and legally competent,⁵⁶ took his own life and had reached a voluntary, clear, settled and informed decision to commit suicide. Furthermore, the person assisting suicide did not provide assistance for improper motives (e.g. personal gain). It is this review that strongly suggests that no prosecution is likely to take place as long as the three Determining Factors are present.

It is important to note that Determining Factor 3 has been phrased to take into account of the fact that, prior to *Nicklinson*, the fact that the provider of the assistance was a medical doctor or healthcare professional was in itself a factor in favour of prosecution.⁵⁷ However, in *Nicklinson*, counsel for the DPP conceded, under DPP's instructions, that the concern of that factor in favour of prosecution was that the doctor would use his professional role to exert undue influence on the assisted.⁵⁸ In October 2014 the DPP clarified its policy to reflect that concession and it is for that reason that Determining Factor 3 has been phrased as is.

Information currently available⁵⁹ shows that the DPP has decided to prosecute the offence of assisted suicide in only two cases, that of Kevin Howe⁶⁰ and Milly Caller,⁶¹ out of 110 cases referred from 1 April 2009 up to 24 April 2015. A review of the decision to prosecute Kevin Howe lends further support to the thesis that no prosecution is likely to take place as long as the three Determining Factors are present. In fact at least two out of the three Determining Factors were absent in Kevin Howe's case. The Court of Appeal has found that when Kevin Howe provided Stephen Walker, the victim, with material with which to set himself on fire, Mr Walker did not have the necessary mental state to reach a voluntary, clear, settled and informed decision to attempt to kill himself. He was a vulnerable adult with a history of mental health problems. The Court of Appeal further said that

'These actions were not carried out in the context of a very elderly and terminally ill person who was suffering and wanted to be put out of their misery. There were no compassionate circumstances. This is not a mercy killing [...]'⁶²

The Court of Appeal's judgment therefore suggests that at least two out of the three Determining Factors (factors 1 and 2) were absent which is likely to explain why the DPP decided to prosecute. Further evidence in support of the proposition that the DPP will prosecute mainly in the absence of the Determining Factors may be obtained once further facts are disclosed by authoritative sources in

Raymond Cutkelvin had pancreatic cancer.

Caroline Loder suffered from multiple sclerosis.

David Arnold, 82, and his wife Elizabeth, 85, decided to end their lives when he became a bed-ridden amputee and she was diagnosed with dementia and Alzheimer's disease. The DPP confirmed that 'The mental capacity of both victims was carefully considered, particularly that of Mrs Arnold, who had dementia. The evidence indicated she was aware of her condition and was clear about what she wanted to happen.' See DPP/CPS, 'Assisted suicide of Dr and Mrs Arnold' (15 January 2014) available at

http://www.cps.gov.uk/news/latest_news/assisted_suicide_of_dr_and_mrs_arnold/.

⁵⁶ All available on the CPS' website at http://www.cps.gov.uk/publications/prosecution/assisted_suicide.html.

⁵⁷ Above n. 50, [43(14)].

⁵⁸ Above n. 1, [142-143].

⁵⁹ Above n 56.

⁶⁰ DPP/CPS, 'Man faces charge of assisted attempted suicide' (27 August 2013) available at http://www.cps.gov.uk/news/latest_news/man_faces_charge_of_assisted_attempted_suicide/.

⁶¹ DPP/CPS, 'One woman charged with encouraging or assisting suicide' (15 September 2014) http://www.cps.gov.uk/news/latest_news/one_woman_charged_with_encouraging_or_assisting_suicide/index.html.

⁶² *R. v Howe* [2014] EWCA Crim 114 at [33].

relation to the decision to prosecute Milly Caller, a lady who supplied gas which her friend Emma Crossman used to kill herself.⁶³

Even if the application of the PAS so far suggests that the DPP will not, as a matter of policy, prosecute whenever all the Determining Factors are present, this does not in itself indicate that doctors or others that assist dying in circumstances where the Determining Factors have been satisfied have a legal right to be immune from prosecution. Lord Hughes in *Nicklinson* said as much:

‘It is legitimate to say that Parliament no doubt recognised that there might be persons who commit the section 2(1) offence, whom it turns out not to be in the public interest to prosecute. That, however, is true of every offence in the criminal calendar. It is not legitimate to suppose that there is a category of such persons which can be identified in advance by the [DPP]. She cannot do so without crossing the constitutional boundary into either changing the law or giving advance exemption from it to a group of potential offenders.’⁶⁴

Undoubtedly, the DPP has not changed the statutory prohibition of assisted suicide and cannot constitutionally do so for similar reasons to those illustrated in part 1. The PAS itself states, at paragraph 6, that

‘This policy does not in any way "decriminalise" the offence of encouraging or assisting suicide. Nothing in this policy can be taken to amount to an assurance that a person will be immune from prosecution if he or she does an act that encourages or assists the suicide or the attempted suicide of another person.’⁶⁵

While due respect is due to Lord Hughes’ statement above and to the various statements of the DPP to the effect that his PAS has not changed the law on assisted suicide, it is a well-settled principle of administrative law that a public body, such as the DPP, is bound in law to follow and apply his policies in a consistent manner. If it is true, as has been argued, that the PAS has been consistently applied so that no prosecutions are brought in cases when the Determining Factors are all present, then under administrative law the DPP is legally bound to continue to decline prosecutions in cases when all Determining Factors are present. A decision to prosecute in a case when the Determining Factors are all present could amount to the DPP acting illegally and being subject to judicial review proceedings.

There is a string of administrative law decisions⁶⁶ where the DPP’s decisions regarding prosecutions have been held illegal on the basis of an improper application of his stated policy. For example, in the context of prosecutions of juvenile offenders, the administrative court has held that

‘the discretion of the CPS to continue or to discontinue criminal proceedings is reviewable by this Court but only where it can be demonstrated that the decision was made regardless of or clearly contrary to a settled policy of the DPP evolved in the public interest, for example, the policy of cautioning juveniles, a policy which the CPS is bound to apply, where appropriate, to the exercise of their discretion to continue or discontinue criminal proceedings.’⁶⁷

⁶³ It appears that Determining Factor 1 might not have been present as ‘the court heard how Crossman had a history of depression, self-harm and drug overdoses’. See The Guardian, ‘Woman cleared of helping friend to kill herself “did not deserve prosecution”’ (14 May 2015) available at <http://www.theguardian.com/uk-news/2015/may/14/woman-not-guilty-helping-friend-kill-herself-assisting-suicide>.

⁶⁴ Above n 1 at [277].

⁶⁵ Above n 50 at [6].

⁶⁶ *R v DPP, ex p. C* [1995] 1 Cr App R 136; *R v DPP, ex p. Manning* [2001] QB 330; *R v DPP, ex p. Jones (Timothy)* [2000] Crim LR 858.

⁶⁷ *R. v Director of Public Prosecutions* [1991] 93 Cr. App. R. 416, at 428.

No doubt, following established case law,⁶⁸ the courts should be very slow to interfere with the DPP's exercise of discretion to prosecute. However, the point here is that the DPP is legally bound to follow his PAS as long as the PAS is in force.⁶⁹ The DPP has consistently applied the PAS in a manner which indicates that no prosecutions will be authorised whenever a person assists suicide when all the Determining Factors have been satisfied. Using Lord Hughes' words, the DPP has in fact exempted from the criminal prohibition 'a category of such persons which can be identified in advance'. This category of persons are those who assist suicide (but not perform euthanasia) under circumstances where all the Determining Factors have been satisfied.

Does the above entail that there is a legal right to be exempt from prosecution for a doctor exercising his conscience-based right to provide assistance in suicide in circumstances where the Determining Factors have been satisfied? It is submitted that there is such a legal right under administrative law as long as the PAS is in force. The DPP/CPS is a public body and, as the case law above indicates, is legally obliged to follow his existing policy. A prosecution of a doctor exercising his conscience-based right to provide assistance in suicide in circumstances where all the Determining Factors have been satisfied would be a clear departure from the policy as practiced. Following the case law above, it would be open for a prosecuted doctor to initiate judicial review proceedings against the DPP of his decision to prosecute him.

No doubt such judicial review proceedings would not be without difficulty. The court would first need to establish that the DPP, when applying the PAS, in fact routinely exempts people offering assistance in circumstances where the Determining Factors have been satisfied. Something similar to the analysis above on the DPP's published decisions on prosecutions of assisted suicide cases may prove useful to the court to reach that conclusion. The court would then need to investigate the facts and be content that the prosecuted doctor did in fact provide assistance in suicide (and did not perform euthanasia) and that the Determining Factors were indeed all satisfied in his particular case. Finally, the court would then need to scrutinise the reasons provided by the DPP to prosecute. Following established case law, the standard to be applied by the court would likely be that the DPP decided to prosecute the doctor 'regardless of or clearly contrary to a settled policy of the DPP',⁷⁰ i.e. the PAS. This would be a very high standard and a rare occurrence, especially given the track record of the DPP/CPS who, as demonstrated by the published decisions, has conscientiously and transparently applied the PAS since it came into force.

Albeit such judicial review proceedings would be filled with many potential pitfalls, they provide a legal recourse to enforce the legal duty on the DPP to follow his PAS which he has consistently applied to exempt people assisting suicide from prosecutions in circumstances where the Determining Factors have all been satisfied.

The UK permissive regime and its impact on the proportionality assessment

The summary of the preceding argument is that under UK administrative law there is a legally enforceable permissive regime on assisted suicide. If this is correct, then it is submitted that the UK's absolute ban on assisted dying is a disproportionate interference with a doctor's conscience-based human right to provide assistance in dying. In particular, it would not be open to UK officials

⁶⁸ See above at n. 66 and 67.

⁶⁹ One cannot exclude the possibility that the DPP may lawfully change his PAS so that it is less permissive. Under administrative law, the publication by a public body of a policy cannot preclude any possible need to change it. See, *R v Secretary of State for the Home Department, ex p. Ruddock* [1987] 1 WLR 1482. However, given the parliamentary approval of the PAS and the wide public consultation that preceded its publication, one may be justified in thinking that, unless Parliament changes the law on assisted dying, it is very unlikely that the PAS will be changed drastically anytime soon.

⁷⁰ See n 67 above.

to argue that interference with that right through an absolute ban is necessary for the pursuit of a legitimate aim. Such argument cannot be made because the UK has already legalised a permissive legal regime administered by the DPP. The making of the argument would be barred by the finding that the UK is applying inconsistent double standards by prohibiting assisted dying without any exceptions under criminal law while creating certain exceptions for it under administrative law. The UK, in effect, has forfeited its ability to argue that an absolute ban is necessary in the pursuit of the legitimate aim of protecting the vulnerable.

To be clear, it is not argued that the UK has forfeited the ability of submitting that a *general* ban is necessary. The argument on the existing permissive legal regime clearly indicates that the regime is limited only to cases of assisted suicide where the Determining Factors are present. It is instead argued that an *absolute* ban is not necessary given that a permissive legal regime exists under administrative law. The consequence of this conclusion on necessity is that a UK court, in a possible *Nicklinson (No. 2)*, should declare that the absolute ban disproportionately interferes with the conscience-based right for a doctor to assist dying.

5. CONCLUSION

It has been argued that certain doctors may rely on article 9 ECHR to claim that they have a conscience-based right to assist the dying of their legally competent adult patients who are unable to put into action without assistance a voluntary, clear, settled and informed decision to commit suicide. This paper has investigated whether there may be legitimate reasons to interfere with that right. In *Carter v Canada*, the Canadian Supreme Court rejected the proposition that an absolute ban on assisted dying was necessary to protect decisionally vulnerable individuals from the risks of requesting assisted dying for undue reasons. The Canadian court accepted that a permissive regime could be put in place with sufficient safeguards. In *Nicklinson*, the UK court did not substantively address that question and it is possible that it may arise again soon. It has been argued that the UK courts should follow the Canadian court's approach. The UK Supreme Court should find that a permissive regime is already in existence in the UK under administrative law principles and therefore that the UK has forfeited its ability to argue that an absolute ban on assisted dying is necessary. The UK Supreme Court should accept that an absolute ban disproportionately interferes with a doctor's conscience-based right to provide assistance in dying.